

# WRIGHT COUNTY CENTRAL POINT OF COORDINATION (CPC) Application Form

**Application Date:** \_\_\_\_\_ **Date Received by CPC Office:** \_\_\_\_\_

**If agency referral, name of agency/contact person and contact information:** \_\_\_\_\_

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **MI:** \_\_\_\_\_

**SSN#:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_ **Sex:**  Male  Female

**Current Address:** \_\_\_\_\_  
Street City State Zip County

**Phone #:** \_\_\_\_\_ **Legal Settlement County:** \_\_\_\_\_

**Ethnic Background:**  White  African American  Native American  Asian  Hispanic  Other \_\_\_\_\_

**Guardian/Payee/Conservator:**  Yes  No

<input type="checkbox"/> Legal Guardian <input type="checkbox"/> Protective Payee <input type="checkbox"/> Conservator (Check any that are appointed and write in name etc.) Name: _____ Address: _____ Phone: _____
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<input type="checkbox"/> Legal Guardian <input type="checkbox"/> Protective Payee <input type="checkbox"/> Conservator (Check any that are appointed and write in name etc.) Name: _____ Address: _____ Phone: _____
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**Veteran Status:**  Yes  No **Branch & Type of Discharge:** \_\_\_\_\_ **Dates:** \_\_\_\_\_

**Marital Status:**  Single  Married  Divorced  Separated  Widowed

**Legal Status:**  Voluntary  Involuntary-Civil  Involuntary-Criminal  Probation  Parole  Jail/Prison

**Living Arrangement:**  Alone  With relatives  With unrelated persons

**Current Residential Arrangement:** (Check applicable arrangement)

<input type="checkbox"/> Private Residence	<input type="checkbox"/> State Hospital School	<input type="checkbox"/> Supported Comm. Living	<input type="checkbox"/> State MHI
<input type="checkbox"/> Foster Care/FLH	<input type="checkbox"/> RCF/MR	<input type="checkbox"/> RCF/PMI	<input type="checkbox"/> RCF
<input type="checkbox"/> ICF	<input type="checkbox"/> ICF/PMI	<input type="checkbox"/> Correctional Facility	
<input type="checkbox"/> Homeless/Shelter/Street	<input type="checkbox"/> ICF/ MR	<input type="checkbox"/> Other _____	

**Disability Group/Primary Diagnosis:**

40-Mental Illness  41-Chronic Mental Illness  42-Mental Retardation  43-Developmental Disability  44-Other

**Specific Diagnosis determined by:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Axis I:** \_\_\_\_\_ **Dx Code:** \_\_\_\_\_

**Axis II:** \_\_\_\_\_ **Dx Code:** \_\_\_\_\_

**Axis III:** \_\_\_\_\_ **Dx Code:** \_\_\_\_\_

**Axis IV:** \_\_\_\_\_ **Dx Code:** \_\_\_\_\_

**Axis V: (GAF Score & date given):** \_\_\_\_\_

**Referral Source:**

<input type="checkbox"/> Self	<input type="checkbox"/> Community Corrections
<input type="checkbox"/> Family/Friend	<input type="checkbox"/> Social Service Agency
<input type="checkbox"/> Targeted Case Management	<input type="checkbox"/> Other _____
<input type="checkbox"/> Other Case Management	

**Education:**

Years of Education: _____
GED: <input type="checkbox"/> Yes <input type="checkbox"/> No
H.S. Diploma: <input type="checkbox"/> Yes <input type="checkbox"/> No
College Degree: _____



**NOTICE: Proof of income may be required with this application including but not limited to pay-stubs, tax-returns, etc. If you have reported no income above, how do you pay your bills? (Do not leave blank if no income is reported!)**

**Household Resources:** (Check and fill in amount and agency):

Type	Amount	Bank, Trustee, or Company
<input type="checkbox"/> Cash	_____	_____
<input type="checkbox"/> Checking Account	_____	_____
<input type="checkbox"/> Savings Account	_____	_____
<input type="checkbox"/> Certificates of Deposit	_____	_____
<input type="checkbox"/> Trust Funds	_____	_____
<input type="checkbox"/> Stocks and Bonds (cash value?)	_____	_____
<input type="checkbox"/> Burial Fund/Life Ins (cash value?).	_____	_____
<input type="checkbox"/> Retirement Funds (cash value?)	_____	_____
<input type="checkbox"/> Other _____	_____	_____
<input type="checkbox"/> Other _____	_____	_____
<b>Total Resources:</b>	_____	

**Motor Vehicles:**  Yes  No      Make & Year: \_\_\_\_\_      Monthly Payment: \_\_\_\_\_  
 (include car, truck, motorcycle, etc.)      Make & Year: \_\_\_\_\_      Monthly Payment: \_\_\_\_\_

**Do you, your spouse or dependent children own or have interest in the following:**

House including the one you live in     Any other real-estate or land     Other \_\_\_\_\_

If yes to any of the above, please explain: \_\_\_\_\_

**Why are you here today? What services do you NEED? (this section must be completed as part of this application!)**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Do you receive any current mental health or substance abuse services (include provider name, location, & dates):**

\_\_\_\_\_  
 \_\_\_\_\_

**Do you take any psychotropic medications? Who prescribed them and what was the date?** \_\_\_\_\_

**What is the name and location of your current general physician:** \_\_\_\_\_

**What is the name and location of your current Pharmacy?** \_\_\_\_\_

**If known, what specific services including provider of those services are requested: (if applicable)**

Service Requested	Provider (if known)	Rate/Unit	Effective Date
Service Requested	Provider (if known)	Rate/Unit	Effective Date
Service Requested	Provider (if known)	Rate/Unit	Effective Date
Service Requested	Provider (if known)	Rate/Unit	Effective Date
Service Requested	Provider (if known)	Rate/Unit	Effective Date

**The above listed services have been discussed with me and are requested with my knowledge and consent. As a signatory of this document, I certify that the above information is true and complete to the best of my knowledge, and I authorize the County CPC staff to check for verification of the information provided including verification with local and/or state Iowa Dept. of Human Services (DHS) staff. I understand that the information gathered in this document is for the use of the County in establishing my ability to pay for services requested, in assuring the appropriateness of services requested, and in confirming legal settlement. I understand that information in this document will remain confidential.**

**Applicant's Signature (or Legal Guardian)** \_\_\_\_\_ **Date** \_\_\_\_\_

Legal Settlement: Legal Settlement is the term used to determine what county will provide funding for requested services. This is determined by a person residing twelve consecutive months (six months for persons considered legally blind) within a county without receiving treatment and/or other support type services for MR/DD/MH/BI/SA and/or Jail or imprisonment. If you do not find one full year at the above address without the above mentioned services please continue until legal settlement can be determined. If someone has received services since the age of majority they will be granted the legal settlement determination of their parents/guardians. Please complete this form to its entirety as much as possible. If you need more space, you may copy this sheet and/or use another sheet of paper.

\*Are you considered legally blind?  Yes  No If yes, when was this determined? \_\_\_\_\_

\*

Current Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ County \_\_\_\_\_

Dates of Residency at this address: \_\_\_\_\_ to \_\_\_\_\_

Services (MH/MR/DD/SA) while at this address:

Type of Service: \_\_\_\_\_

Agency/Location of Service: \_\_\_\_\_

Dates of Service: \_\_\_\_\_ to \_\_\_\_\_

Type of Service: \_\_\_\_\_

Agency/Location of Service: \_\_\_\_\_

Dates of Service: \_\_\_\_\_ to \_\_\_\_\_

Legal Settlement Determined?

Yes, County of Legal Settlement: \_\_\_\_\_

No, Please Continue below

\*

Previous Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ County \_\_\_\_\_

Dates of Residency at this address: \_\_\_\_\_ to \_\_\_\_\_

Services (MH/MR/DD/SA) while at this address:

Type of Service: \_\_\_\_\_

Agency/Location of Service: \_\_\_\_\_

Dates of Service: \_\_\_\_\_ to \_\_\_\_\_

Type of Service: \_\_\_\_\_

Agency/Location of Service: \_\_\_\_\_

Dates of Service: \_\_\_\_\_ to \_\_\_\_\_

Legal Settlement Determined?  Yes, County of Legal Settlement: \_\_\_\_\_

No, Please Continue.

\*

Previous Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ County \_\_\_\_\_

Dates of Residency at this address: \_\_\_\_\_ to \_\_\_\_\_

Services (MH/MR/DD/SA) while at this address:

Type of Service: \_\_\_\_\_

Agency/Location of Service: \_\_\_\_\_

Dates of Service: \_\_\_\_\_ to \_\_\_\_\_

Type of Service: \_\_\_\_\_

Agency/Location of Service: \_\_\_\_\_

Dates of Service: \_\_\_\_\_ to \_\_\_\_\_

Legal Settlement Determined?  Yes, County of Legal Settlement: \_\_\_\_\_

No, Please Continue below

\*

Previous Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ County \_\_\_\_\_

Dates of Residency at this address: \_\_\_\_\_ to \_\_\_\_\_

Services (MH/MR/DD/SA) while at this address:

Type of Service: \_\_\_\_\_

Agency/Location of Service: \_\_\_\_\_

Dates of Service: \_\_\_\_\_ to \_\_\_\_\_

Type of Service: \_\_\_\_\_

Agency/Location of Service: \_\_\_\_\_

Dates of Service: \_\_\_\_\_ to \_\_\_\_\_

Legal Settlement Determined?  Yes, County of Legal Settlement: \_\_\_\_\_

No, Please Continue on additional sheets of paper as needed

I hereby attest that the legal settlement information I have provided is true and accurate to the best of my knowledge and I authorize the County CPC staff to check for verification of the information provided including verification with local and/or state Iowa Dept. of Human Services (DHS) staff. I understand that the information gathered regarding legal settlement is for the use of the County in establishing my ability to pay for services requested. I also understand that information in this document will remain confidential.

Applicant's Signature (or Legal Guardian)

Date

Signature of other completing form if not Applicant or legal Guardian

Date

Contact Person: (including Case Manager, Social Worker, Case Worker, DHS IMW, Agency Staff, Etc.):

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Other Interested person(s):

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**NOTE: DO NOT WRITE IN THE SPACE BELOW-FOR CPC USE ONLY**

Unique ID#: \_\_\_\_\_ Date Contacted: \_\_\_\_\_

Disability Group-DX Type: MI CMI MR DD SA OTHER

Legal Settlement: \_\_\_\_\_ (Attach Legal Settlement Checklist if needed)

Determination: Accepted Denied (see comments below) Pending (see comments below)

Funding Secured: YES NO Arranged: \_\_\_\_\_

Date of Decision: \_\_\_\_\_ Date NOD sent: \_\_\_\_\_

If denied, check applicable reason:

Over income guidelines

Other county of legal settlement \_\_\_\_\_

Does not meet diagnostic criteria

Applicant desires to stop process

Does Not meet service plan criteria

Other \_\_\_\_\_

Does not meet plan criteria

Other referrals given (DHS, TCM, etc.): \_\_\_\_\_

County Co-payment amount/terms (if applicable): \_\_\_\_\_

CPC staff making determination & Date: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_  
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## NOTICE OF PRIVACY PRACTICES

***THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.***

***PLEASE REVIEW IT CAREFULLY.***

If you have any questions about this Notice of Privacy Practices contact Wright County's Privacy Officer:

Russell Wood, Privacy Officer,  
21 2<sup>nd</sup> Ave. NW, Hampton, IA 50441.  
(641) 456-4090

This Notice of Privacy Practices describes how Wright County may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Wright County is required to abide by the terms of this Notice of Privacy Practices. Wright County may change the terms of this notice, at any time. The new notice will be effective for all protected health information that Wright County maintains at that time. Upon request, Wright County will provide you with any revised Notice of Privacy Practices.

### PERMITTED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by Wright County for the purpose of providing or accessing health care services for you. Your protected health information may also be used and disclosed to pay your health care bills and to support the business operation of Wright County.

The following categories describe ways that Wright County is permitted to use and disclose health care information. Examples of types of uses and disclosures are listed in each category. Not every use or disclosure for each category is listed; however, all of the ways Wright County is permitted to use and disclose information falls into one of these categories:

1) Treatment:

Wright County may use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, Wright County would disclose your protected health information, as necessary, to a home health agency that provides care to you. Another example is that protected health information may be provided to a facility to which you have been referred to ensure that the facility has the necessary information to treat you.

2) Payment

Wright County may use and disclose health care information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. Wright County may also discuss your protected health information about a service you are going to receive to determine whether you are eligible for the service, and for undertaking utilization review activities. For example, authorizing a service may require that your relevant protected health information be discussed with a provider to determine your need and eligibility for the service.

3) Healthcare Operations

Wright County may use or disclose, as-needed, your protected health information in order to support its business activities. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing and conducting or arranging for other business

**activities. For example, Wright County may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment or to provide information about alternate services or other health-related benefits.**

Wright County may share your protected health information with third party “business associates” that perform various activities (e.g., billing, transcription services) for Wright County. Whenever an arrangement between Wright County and a business associate involves the use or disclosure of your protected health information, Wright County will have a written contract that contains terms that will protect the privacy of your protected health information.

#### USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRING YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that Wright County has taken an action in reliance on the use or disclosure indicated in the authorization.

Wright County may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then Wright County may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

1) Others Involved in Your Healthcare

Unless you object, Wright County may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person’s involvement in your health care. If you are unable to agree or object to such a disclosure, Wright County may disclose such information as necessary if Wright County, based on its professional judgment, determines that it is in your best interest. Wright County may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, Wright County may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2) Emergencies

Wright County may use or disclose your protected health information in an emergency treatment situation. If this happens, Wright County shall try to obtain your acknowledgment of receipt of the Notice of Privacy Practices as soon as reasonably practicable after the delivery of treatment.

#### OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR AUTHORIZATION OR OPPORTUNITY TO OBJECT

Wright County may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

1) Required By Law

Wright County may use or disclose your protected health information to the extent that the law requires the use or disclosure. You will be notified, as required by law, of any such uses or disclosures.

2) Public Health

Wright County may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. Wright County may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

3) Communicable Diseases

Wright County may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease.

4) Health Oversight

Wright County may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this

information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

5) Abuse or Neglect

Wright County may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, Wright County may disclose your protected health information if it believes that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

6) Food and Drug Administration

Wright County may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

7) Legal Proceedings

Wright County may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

8) Law Enforcement

Wright County may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on county premises, and (6) medical emergency (not on Wright County's premises) and it is likely that a crime has occurred.

9) Coroners, Funeral Directors, and Organ Donation

Wright County may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

10) Research

Wright County may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

11) Criminal Activity

Consistent with applicable federal and state laws, Wright County may disclose your protected health information, if it believes that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. Wright County may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

12) Military Activity and National Security

When the appropriate conditions apply, Wright County may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military service. Wright County may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

13) Workers' Compensation

Your protected health information may be disclosed by Wright County as authorized to comply with workers' compensation laws and other similar legally established programs.

14) Inmates

Wright County may use or disclose your protected health information if you are an inmate of a correctional facility and Wright County created or received your protected health information in the course of providing care to you.

15) Required Uses and Disclosures

Under the law, Wright County shall make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine Wright County's compliance with the requirements of 45 C.F.R. section 164.500 et. seq.

**YOUR RIGHTS**

The following are a list of your rights with respect to your protected health information and a brief description of how you may exercise these rights:

**RIGHT TO INSPECT AND COPY YOUR PROTECTED HEALTH INFORMATION**

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as Wright County maintains the protected health information. A "designated record set" contains medical and billing records and any other records that Wright County uses in making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact the Wright County Privacy Officer if you have questions about access to your medical record.

**RIGHT TO REQUEST A RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION**

This means you may ask Wright County not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Wright County is not required to agree to a restriction that you may request. If Wright County believes that it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If Wright County does agree to the requested restriction, it may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with Wright County. You may request a restriction in writing to the Wright County Privacy Officer.

**RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS FROM WRIGHT COUNTY BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION**

Wright County will accommodate reasonable requests. Wright County may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. Wright County will not request an explanation from you as to the basis for the request. Please make this request in writing to the Wright County Privacy Officer.

**RIGHT TO REQUEST AN AMENDMENT TO YOUR PROTECTED HEALTH INFORMATION**

This means you may request an amendment of protected health information about you in a designated record set for as long as Wright County maintains this information. In certain cases, Wright County may deny your request for an amendment. If Wright County denies your request for amendment, you have the right to file a statement of disagreement with Wright County and Wright County may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. All requests for amendments must be in writing.

**RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION**

This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures Wright County may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003.

**RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE**

You have the right to obtain a paper copy of this notice, upon request, even if you have agreed to accept this notice electronically.

### **COMPLAINTS**

You may file a complaint to Wright County or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by Wright County. You may file a complaint against Wright County by notifying the Wright County Privacy Officer. Wright County will not retaliate against you for filing a complaint.

You may contact Wright County Privacy Officer, Russell Wood, 21 2<sup>nd</sup> Ave. NW, Hampton IA 50441 (641) 456-4090 for further information about the complaint process.

This notice was published and becomes effective on **April 14, 2003**.

**ACKNOWLEDGMENT OF  
RECEIPT OF  
NOTICE OF PRIVACY PRACTICE**

I, \_\_\_\_\_, do hereby  
acknowledge receipt of a copy of the Notice of Privacy Practice, Policy and Procedure.

Signature of Individual

\_\_\_\_\_  
Date

IN THE EVENT THIS NOTICE IS RECEIVED BY THE INDIVIDUAL'S PERSONAL  
REPRESENTATIVE

\_\_\_\_\_  
Signature of personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Legal authority of personal representative